STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENT LIVING CLUB	6038 W 25TH ST INDIANAPOLIS, IN 46224

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R000000	This visit was for the Investigation of Complaints IN00152030 and IN00152686. Complaint IN00152030 - Substantiated. State deficiencies related to the allegations are cited at R0241, R0247, R0298 and R0412, . Complaint IN00152686 Substantiated. State deficiency related to the allegation is cited at R0149. Survey Dates: July 17 & 18, 2014 Facility number: 001132 Provider number: NA AIM number: NA Survey Team: Mary Jane G. Fischer RN Census bed type: Residential: 44 Total: 44 Census payor type: Other: 44 Total: 44 Sample: 7	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Supplemental sample: 3 These State findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 7/21/14 by Brenda Marshall, RN.			
R000149	410 IAC 16.2-5-1.5(f) Sanitation and Safety Standards - Deficiency (f) The facility shall have a pest control program in operation in compliance with 410 IAC 7-24. Based on observation, record review and interview, the facility failed to ensure an effective pest control program and that the facility environment was free from tiny, flying insects. This deficient practice effected all areas of the facility, including kitchen, dining room, resident rooms and bathrooms, the nurses' station, conference room work area and bathroom, and all common areas. Findings include: During the initial tour of the facility on 07-17-14 at 9:00 a.m., with the Director of Operations in attendance, as each resident room was entered with the permission of the resident, tiny, flying insects could be observed flying around	R000149	The corrective action accomplished was to install the bug lights that the surveyor talked to the pest control agent about and to get the hot spot foam she also talked to him about the facility will id other residents having the potential to be affected by watching resident rooms that do not have gnats to ensure they do not get them the measures put into place were to install the bug lights and have the pest control bring the hot spot foam to kill the gnat eggs the corrective actions will be monitored by the maintenance and housekeeping staff by touring res rooms daily and also the pest control comp is on site two times a week monitoring the situation. addendum: the facility does and will continue to monitor resident rooms on a daily basis to ensure	07/24/2014

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	and landing on furniture, bedding, inanimate objects and bathroom fixtures. The Director of Operations indicated there was a problem with the gnats. A review of the contracted Pest Control company invoices indicated the facility received general pest control treatment monthly from January 2014 thru June 2014. The invoices did not indicate any special treatment for the gnats. During an interview on 07-17-14 at 10:15 a.m., a dietary staff member employee #5 indicated, "I've seen the gnats, but we don't have roaches or mice. They're everywhere. They're bad this time of the year. " During an interview on 07-17-14 at 10:30 a.m., the housekeeper employee #6 indicated the gnats had gotten worse lately and that one flew in her eye the other day, and it was "hard to get it out of my eye." The housekeeper indicated she had put vinegar and baking soda down the resident bathroom drains, but that only works "for a short time. Part of the problem is the residents have wet towels, washcloths, partially filled coffee cups and water glasses in their rooms which just make the matter worse." On 07-18-14 at 9:15 a.m. the		compliance. this will continue as long as a resident resides in the rooms. the housekeeping staff is the main staff doing the tours as they do the routine cleaning services. the maint staff over sees should a problem arise. the housekeeping staff reports in to the office mgr and maint super if they see a problem with gnats. the pest control company is on site once a week monitoring the gnats as well. the staff tours with the pest control company and keeps an ongoing progress list. this is kept with the office mgr. the pest control also ensures the lights are working properly as well.	

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	representative of the contracted pest control company was interviewed. The representative indicated he was unaware the problem of the gnats had gotten so bad. " I used strips to try and trap them. They [in regard to the gnats] breed at a high rate. They just breed so fast. I'm going to have to find the main source of the problem in the building. The treatment of the baking soda and the vinegar only takes off the top layer, but that doesn't solve the problem. I'll have to get a special foam called " Hot Spot " because that product will eat the enzymes where they are laying their eggs. " This State rule relates to Complaint IN00152686.			
R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review, observation, and interview, the facility failed to ensure prophylactic medications prescribed for diagnosis of possible tuberculosis were administered according to physicians' orders for 3 of 3 residents reviewed for	R000241	the corrective action accomplished is to ensure prophylactic meds are administered correctly. the facility will id other residents having the potential to be affected by a med audit of any other resident receiving a prophylactic med. the	07/30/2014

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	medication administration in a sample of 7 residents (Residents B, D, and E). Findings include: 1. The record for Resident "B" was reviewed on 07-17-14 at 10:35 a.m. Diagnoses included, but were not limited to, positive PPD (Purified Protein Derivative - a method use to diagnose tuberculosis infection), history of cocaine and alcohol abuse, and chronic paranoid schizophrenia. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 12-31-13. Prior to admission to the facility the resident had a chest x-ray. During an interview on 07-18-14 at 8:15 a.m., a concerned Marion County Health Nurse indicated the resident was being treated with prophylactic medications for tuberculosis at the time of admission. " I gave the facility a one month supply of the medications when he got there. When I went back to the facility I noticed there were still capsules left in the original bottle. I told the Director of Nurses and spoke with the doctor." The current physician order, dated 04-11-14, instructed the nurse to administer Rifampin (a medication in the		measures put into place will be the nursing staff will be in compliance with the regs and of their own professional practice of med administration. the rn provided medication education to the nursing staff re this finding. the rn moved the locale of said meds in question to the top drawer of med cart. a sign in sheet is made of med received. if a duplicate bottle is sent to the facility from the pharmacy, it will be immediately returned and not kept as it was in this case. the rn will monitor her staff as to the meds prescribed. the rn will accept all dr orders herself on an admin record that was created by the rn the nsg staff was inserviced on this policy july 30,2014 addendum: the facility will not accept any meds that are not from the ordered prescriber. the DON does random med pass observation of the nsg staff at all of our med times to ensure the nsg staff is performing their job duties correctly. by checking at random times and with different staff members, the DON ensures to see all of the staff, therefore keeping in compliance. the monitoring of the med records in done 4x a month. the pharmacy sends the med sheet, the DON audits med sheet, makes all changes, the medical director confirms the DON audit by signing off on the med sheet, then the pharmacy consultant	

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	treatment of latent tuberculosis), 300 mg (millegrams) 2 capsules orally once a day time four months. " During an observation on 07-17-14 at 11:00 a.m., with the Registered Nurse # 3 and Qualified Medication Aide #8 in attendance the medication was reviewed, and the capsules were counted. The resident had three bottles of the medication. Bottle #1 was dated 05-09-14 and indicated 60 capsules were delivered. The Registered Nurse indicated 40 capsules remained in the bottle. Bottle #2 was dated 06-06-14 and indicated 60 capsules were delivered. The Registered Nurse indicated 44 capsules remained in the bottle. Bottle #3 was dated 07-04-14 and indicated 60 capsules were delivered. The Registered Nurse indicated 41 capsules remained in the bottle. At the time of this observation, the 07-04-14 bottle #3, 26 doses should have been administered to the resident and not the 19 doses as indicated by the nurse. Further review of the resident record contained a "Contract for Assisted		checks the med sheet upon return to the pharmacy for monthly fill. the monthly fill comes in atc packs from the pharmacy. should there be a med change, the DON will update med book immediately upon notification from dr. as well as make changes in atc pack and notify prescriber of said changes. charting is done also in resident file. the DON will continue to ensure compliance daily during her continued job duties. the medical director is also in contact with DON should any problems arise.	

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	Living" dated 12-31-13, which indicated, "Medication monitoring service shall include monitoring correct medication at prescribed times," which was signed by the resident. During this observation the Qualified Medication Aide indicated the resident did not refuse his medications. The Qualified Medication Aide further stated, " I don' t know why they keep bringing us more medication when we haven't finished these bottles yet." 2. The record for Resident "D" was reviewed on 07-17-14 at 11:30 a.m. Diagnoses included, but were not limited to, schizo-effective disorder, vascular dementia, tobacco use and frontal lobe stroke. These diagnoses remained current at the time of the record review. A review of a recent chest x-ray dated 02-27-14 indicated, "Patient Care Advisory on [name of resident]. Please note that a chest x-ray on the resident noted above which was reported with a positive result. Consider this a courtesy reminder that a reassessment of the resident may be necessary at this time." The examination results indicated - "Active TB (tuberculosis) cannot be excluded."			

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	A physician order dated 02-28-14 instructed the nursing staff to administer Rifampin 300 mg capsule 1 orally once a day. The record lacked any further assessment. A nurses note dated 04-08-14 at 10:00 p.m., indicated "Res. [resident] spitting up blood in a bag. This writer caught him doing this around 9:00 a.m. Res. is being sent to [name of local area hospital] ER [Emergency Room] with blood in bag." The resident returned to the facility with 2 prescriptions which included Prednisone (a steroid) and Doxycycline (an antibiotic). No further assessment was conducted for this resident. The nurses notes further indicated the resident was to be seen by an Infectious Disease physician on 06-10-14. The clinical record lacked documentation of the purpose or results from this physician visit. During an observation on 07-17-14 at 11:00 a.m., with the Registered Nurse # 3 and Qualified Medication Aide #8 in attendance the medication Rifampin, were observed. The resident had three bottles of the medication.			

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	Bottle #1 was dated 06-15-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 26 capsules remained. Bottle #2 was dated 07-13-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 30 capsules remained. Further review of the resident record contained a "Contract for Assisted Living," dated 11-2009 which indicated, "Medication monitoring service shall include monitoring correct medication at prescribed times," and was signed by the resident. During this observation the Qualified Medication Aide #8 indicated the resident did not refuse medications. 3. The record for Resident "E" was reviewed on 07-17-14 at 12:00 p.m. Diagnoses included, but were not limited to, emphysema, hypertension, positive PPD and a history of TB. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 10-15-2010 and had a chest x-ray prior to admission. The record included the resident's most recent chest x-ray dated 02-27-14 which			

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	indicated, "Patient Care Advisory on [name of resident]. Please note that a chest x-ray on the resident noted above which was reported with a positive result. Consider this a courtesy reminder that a reassessment of the resident may be necessary at this time." The examination results indicated, "Active TB cannot be excluded." A physician order dated 02-28-14 instructed the nursing staff to administer Rifampin 300 mg capsule 1 orally once a day - " no stop date." The record lacked any further assessment. During an observation on 07-17-14 at 11:00 a.m., with the Registered Nurse # 3 and Qualified Medication Aide #8 in attendance the medications were observed. The resident had three bottles of the medication. Bottle #1 was dated 05-23-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 21 capsules remained. Bottle #2 was dated 06-20-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 14 capsules remained.			

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	Further review of the resident record contained a "Contract for Assisted Living," dated 10-15-10 which indicated, "Medication monitoring service shall include monitoring correct medication at prescribed times," which was signed by the resident. During this observation the Qualified Medication Aide #8 indicated the resident did not refuse his medications. This State tag relates to Complaint IN00152030.			
R000247	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on record review, observation, and interview, the facility failed to ensure the physician was notified of medication errors and failed to ensure documentation of the errors in residents' records for 3 of 3 residents reviewed for medication errors in a sample of 7 (Residents B, D and E).	R000247	the corrective action is to notify the physician of all future med errors as well as document them in the residents files the facility will id other residents by doing a count of all vial meds the measures put into place are to do a count of all vial meds, meds of this nature, not in atc packs, will remain in the top drawer of med cart with a sign in sheet. these	07/30/2014

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	Findings include: 1. The record for Resident "B" was reviewed on 07-17-14 at 10:35 a.m. Diagnoses included, but were not limited to, positive PPD (Purified Protein Derivative - a method use to diagnose tuberculosis infection), history of cocaine and alcohol abuse, and chronic paranoid schizophrenia. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 12-31-13. Prior to admission to the facility the resident had a chest x-ray. During an interview on 07-18-14 at 8:15 a.m., a concerned Marion County Health Nurse indicated the resident was being treated with prophylactic medications for tuberculosis at the time of admission. "I gave the facility a one month supply of the medications when he got there. When I went back to the facility I noticed there were still capsules left in the original bottle. I told the Director of Nurses and spoke with the doctor." The current physician order, dated 04-11-14, instructed the nurse to administer Rifampin (a medication in the treatment of latent tuberculosis), 300 mg (millegrams) 2 capsules orally once a day times four months. "		sheets will be signed in and out for all meds that come before the new atc packs arrive the facility met with the medical director to whom these residents in question have been repeatedly reported to said director. the med director is confident the proof of meds were administered. the med dir stated that if they were not there would have been evidence of granulomatous tissue. there was no indication on f/u cxr. the meeting with med director and nursing education was july 30, 2014 addendum: the facility adapted a form from briggs for med errors.it includes space for resident name, date, times, med, dosage, who made error, place for physician notes, descriptions, outcomes, and actions taken. it is available for use by the nursing staff. the DON will report all med errors to the physician. med compliance is observed daily by all nsg staff during all med passes. if any med errors are noticed, the don would be immediately notified. she in turn will immediately notify the physician. the new form adapted would be used in this instance and sent to med director, physician and filed in resident file. this will be continued on a daily basis as long as the facility exists.	

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	During an observation on 07-17-14 at 11:00 a.m., with the Registered Nurse #3 and Qualified Medication Aide #8 in attendance the medication was reviewed, and the capsules were counted. The resident had three bottles of the medication. Bottle #1 was dated 05-09-14 and indicated 60 capsules were delivered. The Registered Nurse indicated 40 capsules remained in the bottle. Bottle #2 was dated 06-06-14 and indicated 60 capsules were delivered. The Registered Nurse indicated 44 capsules remained in the bottle. Bottle #3 was dated 07-04-14 and indicated 60 capsules were delivered. The Registered Nurse indicated 41 capsules remained in the bottle. At the time of this observation, of the 07-04-14 bottle #3, 26 doses should have been administered to the resident and not the 19 doses as indicated by the nurse. During this observation the Qualified Medication Aide indicated the resident did not refuse his medications. The Qualified Medication Aide further stated, " I don' t know why they keep bringing us			

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	more medication when we haven't finished these bottles yet." The record lacked documentation the physician was notified of the medication error. 2. The record for Resident "D" was reviewed on 07-17-14 at 11:30 a.m. Diagnoses included, but were not limited to, schizo-effective disorder, vascular dementia, tobacco use and frontal lobe stroke. These diagnoses remained current at the time of the record review. A review of a recent chest x-ray dated 02-27-14 indicated, "Patient Care Advisory on [name of resident]. Please note that a chest x-ray on the resident noted above which was reported with a positive result. Consider this a courtesy reminder that a reassessment of the resident may be necessary at this time." The examination results indicated - "Active TB cannot be excluded." A physician order, dated 02-28-14 instructed the nursing staff to administer Rifampin 300 mg capsule -1 orally - once a day. During an observation on 07-17-14 at 11:00 a.m., with the Registered Nurse # 3 and Qualified Medication Aide #8 in			

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	attendance the medication Rifampin, were observed. The resident had three bottles of the medication. Bottle #1 was dated 06-15-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 26 capsules remained. Bottle #2 was dated 07-13-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 30 capsules remained. Further review of the resident record contained a "Contract for Assisted Living," dated 11-2009 which indicated, "Medication monitoring service shall include monitoring correct medication at prescribed times," and was signed by the resident. The resident's record lacked documentation the physician had been notified of the medication error. 3. The record for Resident "E" was reviewed on 07-17-14 at 12:00 p.m. Diagnoses included, but were not limited to, emphysema, hypertension, positive PPD and a history of TB. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 10-15-2010			

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		A. BUILDING 00 B. WING	07/18/2014

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	and had a chest x-ray prior to admission. The record included the resident's most recent chest x-ray dated 02-27-14 which indicated, "Patient Care Advisory on [name of resident]. Please note that a chest x-ray on the resident noted above which was reported with a positive result. Consider this a courtesy reminder that a reassessment of the resident may be necessary at this time." The examination results indicated, "Active TB cannot be excluded." A physician order dated 02-28-14 instructed the nursing staff to administer Rifampin 300 mg capsule 1 orally once a day - "no stop date." During an observation on 07-17-14 at 11:00 a.m., with the Registered Nurse # 3 and Qualified Medication Aide #8 in attendance the medications were observed. The resident had three bottles of the medication. Bottle #1 was dated 05-23-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 21 capsules remained. Bottle #2 was dated 06-20-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 14			

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	capsules remained. Further review of the resident record contained a "Contract for Assisted Living," dated 10-15-10 which indicated, "Medication monitoring service shall include monitoring correct medication at prescribed times," which was signed by the resident. The resident's record lacked documentation the physician had been notified of the medication error. This State tag relates to Complaint IN00152030.			
R000298	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review, observation, and interview the pharmacist failed to identify any medication irregularities in the	R000298	the corrective action is to notify the consultant of the deficiency. the facility will discuss with the	08/08/2014

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	resident's medication regime, in that when residents had specific physician orders for prophylactic medications in the treatment of tuberculosis, the pharmacist failed to reconcile the medications and alert the Administrative staff of any irregularity in the residents medication regime for 3 of 3 residents with diagnoses of possible tuberculosis in a sample of 7. (Residents "B", "D" and "E"). Findings include: 1. The record for Resident "B" was reviewed on 07-17-14 at 10:35 a.m. Diagnoses included, but were not limited to, positive PPD (Purified Protein Derivative - a method use to diagnose tuberculosis infection), history of cocaine and alcohol abuse, and chronic paranoid schizophrenia. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 12-31-13. Prior to admission to the facility the resident had a chest x-ray. During an interview on 07-18-14 at 8:15 a.m., a concerned Marion County Health Nurse indicated the resident was being treated with prophylactic medications for tuberculosis at the time of admission. " I gave the facility a one month supply of		consultant so she can ensure no other residents have potential to be affected by her own means of practice the measure put into place will be that of the pharm consultant as this facility does not employ her. it is not this facilities deficient practice. it is that of the pharmacy meeting with the consultant again the week of august 4th, 2014 addendum: the facility met with the rx consultant and relayed the info. in question. the consultant then had a meeting with her supervisors and let them know info. as well as the med cart techs that come to all of their contracted facilities. they used the info given to them as a teaching tool for their staff to ensure they are meeting compliance when they visit the facility. addendum: the facility has been given the grievance policy from the pharmacy and instructions if it is deemed necessary to use. the facility will investigate any discrepancy and report to the pharmacy. the facility has also been given the pharmacy policy and procedures for dispensing errors. the facility is to follow pharmacy protocol for appropriateness should a problem arise. the consultant pharmacist will be responsible for general supervision of accountability dispensed meds. a report of said findings will be provided to the don and director to ensure communication on the status of pharmaceutical service	

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	the medications when he got there. When I went back to the facility I noticed there were still capsules left in the original bottle. I told the Director of Nurses and spoke with the doctor." The current physician order, dated 04-11-14, instructed the nurse to administer Rifampin (a medication in the treatment of latent tuberculosis), 300 mg (millegrams) 2 capsules orally once a day time four months. " During an observation on 07-17-14 at 11:00 a.m., with the Registered Nurse # 3 and Qualified Medication Aide #8 in attendance the medication was reviewed, and the capsules were counted. The resident had three bottles of the medication. Bottle #1 was dated 05-09-14 and indicated 60 capsules were delivered. The Registered Nurse indicated 40 capsules remained in the bottle. Bottle #2 was dated 06-06-14 and indicated 60 capsules were delivered. The Registered Nurse indicated 44 capsules remained in the bottle. Bottle #3 was dated 07-04-14 and indicated 60 capsules were delivered. The Registered Nurse indicated 41		within the facility. the consultant said she was going to have a quality assurance meet with her staff to help identify these excessive quantities throughout all of the facilities they contract with. they hope to enhance the effectiveness of their services through this process.	

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	capsules remained in the bottle. At the time of this observation, of the 07-04-14 bottle #3, 26 doses should have been administered to the resident and not the 19 doses as indicated by the nurse. Further review of the resident record contained a "Contract for Assisted Living" dated 12-31-13, which indicated, "Medication monitoring service shall include monitoring correct medication at prescribed times," which was signed by the resident. During this observation the Qualified Medication Aide indicated the resident did not refuse his medications. The Qualified Medication Aide further stated, " I don' t know why they keep bringing us more medication when we haven't finished these bottles yet." A review of the June 2014 re-write of physician orders indicated the medications were reviewed by the pharmacist. 2. The record for Resident "D" was reviewed on 07-17-14 at 11:30 a.m. Diagnoses included, but were not limited to, schizo-effective disorder, vascular dementia, tobacco use and frontal lobe stroke. These diagnoses remained			

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	current at the time of the record review. A review of a recent chest x-ray dated 02-27-14 indicated, "Patient Care Advisory on [name of resident]. Please note that a chest x-ray on the resident noted above which was reported with a positive result. Consider this a courtesy reminder that a reassessment of the resident may be necessary at this time." The examination results indicated - "Active TB (tuberculosis) cannot be excluded." A physician order dated 02-28-14 instructed the nursing staff to administer Rifampin 300 mg capsule 1 orally once a day. During an observation on 07-17-14 at 11:00 a.m., with the Registered Nurse # 3 and Qualified Medication Aide #8 in attendance the medication Rifampin, were observed. The resident had three bottles of the medication. Bottle #1 was dated 06-15-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 26 capsules remained. Bottle #2 was dated 07-13-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 30			

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	capsules remained. Further review of the resident record contained a "Contract for Assisted Living," dated 11-2009 which indicated, "Medication monitoring service shall include monitoring correct medication at prescribed times," and was signed by the resident. A review of the June 2014 re-write of physician orders indicated the medications were reviewed by the pharmacist. 3. The record for Resident "E" was reviewed on 07-17-14 at 12:00 p.m. Diagnoses included, but were not limited to, emphysema, hypertension, positive PPD and a history of TB. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 10-15-2010 and had a chest x-ray prior to admission. The record included the resident's most recent chest x-ray dated 02-27-14 which indicated, "Patient Care Advisory on [name of resident]. Please note that a chest x-ray on the resident noted above which was reported with a positive result. Consider this a courtesy reminder that a reassessment of the resident may be necessary at this time." The examination			

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	results indicated, "Active TB cannot be excluded." A physician order dated 02-28-14 instructed the nursing staff to administer Rifampin 300 mg capsule 1 orally once a day - " no stop date." During an observation on 07-17-14 at 11:00 a.m., with the Registered Nurse # 3 and Qualified Medication Aide #8 in attendance the medications were observed. The resident had three bottles of the medication. Bottle #1 was dated 05-23-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 21 capsules remained. Bottle #2 was dated 06-20-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 14 capsules remained. Further review of the resident record contained a "Contract for Assisted Living," dated 10-15-10 which indicated, "Medication monitoring service shall include monitoring correct medication at prescribed times," which was signed by the resident. A review of the June 2014 re-write of			

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	physician orders indicated the medications were reviewed by the pharmacist. During interview on 07-18-14 at 10:30 a.m., the Qualified Medication Aide #8 indicated that when the pharmacist was "here she went through the med. [medication] cart, but never said anything. She's new." This State tag relates to Complaint IN00152030.			
R000412	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on record review and interview, the facility failed to ensure that resident's who had a history of tuberculosis or a positive PPD (Purified Protein Derivative - a method used to diagnose silent tuberculosis infection) had continued annual risk assessments, in that when residents were identified with diagnoses	R000412	the corrective action taken is to ensure all residents with a history of positive ppd have an annual risk assessment done. the facility id other residents having the potential to be affected by an audit to see if any other res had a positive ppd other than the three in question already the measures put into place were to have the	07/30/2014

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	which included a positive skin test, or a history of tuberculosis the facility failed to assess the residents annually for signs and symptoms suggestive of tuberculosis for 3 of 3 supplemental sampled residents. (Residents " H", " I", and "J"). Findings include: 1. The record for Resident "H" was reviewed on 07-18-14 at 8:40 a.m. Diagnoses included, but were not limited to, a positive PPD. The resident was admitted to the facility on 10-02-2009 and had a chest x-ray at the time of admission. During clinical record review, the last chest x-ray for this resident was dated 01-16-2013. The record lacked an annual TB risk assessment. 2. The record for Resident "I" was reviewed on 07-18-14 at 9:30 a.m. Diagnoses included, but were not limited to, a history of tuberculosis. The resident was admitted to the facility on 07-27-11. The record contained a chest x-ray dated 07-26-11. The last PPD testing was documented on 04-06-2012 with a negative result. The resident record lacked further PPD testing or an annual TB risk assessment.		medical director along with the rn perform the assessments on the three residents in question. if any other should arise in the future they will be assessed annually, as well as the 3 in question will continue to be annually assessed. the surveyor gave us a form while she was on site for future assessment. the rn will monitor any future resident admitted with the potential for tb. the medical director will also monitor per our meeting july 30, 2014 addendum: the facility will ensure the screenings are done by the new log book and schedule implemented together by the nursing staff and office staff. all resident charts were audited to ensure each has an up to date tb test or cxr. if they did not, one was completed. a copy has been made of each original tb test or cxr of all residents and put into the new log book the original is left in the chart itself. a monthly schedule is in the log book as well to ensure future yearly compliance. the don will have a copy to complete any needed yearly tb tests or cxr upon the new month. any new admit is added to the log book info as well as the copy of tb or cxr upon their admission. the log book is kept in a safe in the office. the copies of the schedule are updated upon new admits or changes in resident situation. the copies are given to nursing staff upon any change. the medical director has	

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	3. The record for Resident "J" was reviewed on 07-18-14 at 10:00 a.m. Diagnoses included, but were not limited to, a positive PPD test dated 11-01-2012 and the record indicated a local medical group determined the resident had "latent" TB which was "not contagious." The record further indicated the resident received prophylactic medication prior to the admission date of 07-10-2013. The record lacked further testing including a chest x-ray or annual TB risk assessment since the time of admission. During an interview on 07-18-14 at 10:30 a.m. the Qualified Medication Aide employee #8 indicated she was unaware of a form to be completed to assess the resident. " I know we don't have those here." This State tag relates to Complaint IN00152030.		also implemented bringing a scanner for all of her med records and changes upon her visits. the med director will keep these copies in her office for a triple back up. the office manager maintains the log book with info given to her in nursing report by the don and entire nsg staff.	